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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Resources and Services Administration

FORM 1A: GENERAL INFORMATION WORKSHEET

FOR HRSA USE ONLY	
Application Tracking Number	Grant Number

1. Applicant Information

Applicant Name			
Application Type		Existing Grantee	
Grant Number		UDS #	
Business Entity			
Organization Type	**[_]** Tribal **[_]** Urban Indian **[_]** Faith based **[_]** Hospital **[_]** State government **[_]** City/County/Local Government or Municipality **[_]** University **[_]** Community based organization		

2. Proposed Service Area

Applicants applying for Community Health funding should provide at least one designated service area ID being proposed to serve under an MUA or MUP.

2a. Service Area Designation **(Use commas to separate multiple IDs)**	**[_]** Medically Underserved Area (ID#____) **[_]** Medically Underserved Population (ID#____) **[_]** MUA Application Pending (ID#____) **[_]** MUP Application Pending (ID#____) **[_]** Serving Section 330 (G) - Migrant Health Centers **[_]** Serving Section 330 (H) - Homeless Health Centers **[_]** Serving Section 330 (I) - Public Housing Health Centers
2b. Target Population Type	**[_]** Urban **[_]** Rural

GENERAL INFORMATION Refer to the guidance to accurately complete the below information.

2c. Target Population and Provider Information

Target Population Information	Current Number	Projected at End of Project Period
Total Service Area Population		
Total Target Population		
Total FTE Medical Providers		
Total FTE Dental Providers		
Total FTE Behavioral Health Providers		
Total FTE Substance Abuse Service Providers		

Data reported below should not be duplicated for patients and visits.

Patients and Visits by Service Type

Service Type	Current Number		Projected at End of Project Period	
	Patients	Visits	Patients	Visits
Total Medical				
Total Dental				
Total Mental Health				
Total Substance Abuse				

Patients and Visits by Population Type

POPULATION TYPE	Current Number (b)		Number at End of Year 1		Number After Year 2 (c)		Number at End of Project Period		Change in New Users After 2 Years (d) = (c-b)		Percent Change in New Users After 2 Years (e) = (d/b)*100	
	Patients	Visits	Patients	Visits	Patients	Visits	Patients	Visits	Patients	Visits	Patients	Visits
General Community												
Migrant/Seasonal Farm workers												
Public Housing Residents												
Homeless Persons												
TOTAL												

Note: The following sections are not applicable for Budget Period Renewal applications: Funding Preference, Funding Priority and Target Population by County.

3. Funding Preference

Indicate if the following preference is requested:

[_] Sparsely Populated (persons/square mile: 7)

Please attach evidence that supports your preference request (e.g., census bureau documentation)

4. Funding Priority

Select priority type you are requesting below:

[_] Multi-county (Must demonstrate that a minimum of 15 percent of the total target population will come from county(ies) other than the eligible high priority county) **(PI 2 Only)**

5. Target Population by County

County Name	Targeted County	Number From Total Target Population	Percent of Target Population
Total			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **Health Resources and Services Administration** **FORM 1 - PART C: DOCUMENTS ON FILE**	**FOR HRSA USE ONLY**			
	Grantee Name			
	Grant Number		Application Tracking Number	

	DATE OF LATEST REVISION
MANAGEMENT AND FINANCE	DATE
Personnel Policies and Procedures	
Conflict of Interest Policies and Procedures	
Data Collection and Information Systems	
Agreements with Medicaid and Medicare	
Billing and Collection Policies and Procedures	
Procurement Policies and Procedures	
Emergency Preparedness and Management Plan	
Travel Policies	
Fee Schedule	
Accounting Policies and Procedures Manual	
Documentation of FQHC rates	
Contracts with Agencies, Vendors, etc.	
Legal Documents related to federal interest in real property	
CLINICAL PROGRAM	DATE
Patient Confidentiality Policy and Procedures	
Principles of Practice (As applicable)	
List of Non-Physician Supervision Protocols	
Health Maintenance Protocols by Age Group	
Clinical Protocols	
Continuing Professional Education Policies	
Patient Flow	
Sample Medical Record	
Clinical Information and Tracking Systems	
Patient Grievance Policy and Procedure	
Quality Management and/or Assurance Plan [1]	
Malpractice Coverage and/or FTCA Deeming/Malpractice Coverage Provisions	
OSHA Documents	
CLIA Documents	
Credentialing Policy and Procedures	
OTHER DOCUMENTS	DATE
Current MUA or MUP designation	
Current HPSA designation	
Frontier Area Documentation	

[1] This should include Incident Reporting System and Risk Management Plans/Policies

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DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 2 – STAFFING PROFILE	FOR HRSA USE ONLY	
	Grant Number	Application Tracking Number

PERSONNEL BY CATEGORY	TOTAL FTEs (a)	ANNUAL SALARY OF POSITION (b)	TOTAL SALARY (a * b)
ADMINISTRATION			
Executive Director / CEO			
Finance Director (Fiscal Officer) / CFO			
Chief Operating Officer / COO			
Chief Information Officer / CIO			
Administrative Support Staff			
MEDICAL STAFF			
Medical/Clinical Director			
Family Physicians			
General Practitioners			
Internists			
OB/GYNs			
Pediatricians			
Other Specialty Physicians: Please Specify:_____			
Physician Assistants/Nurse Practitioners			
Certified Nurse Midwives			
Nurses (RNs, LVNs, LPNs)			
Pharmacist, Pharmacy Support, Technicians			
Other Medical Personnel: Please Specify:_____			
Laboratory Personnel (Lab Technicians)			
X-ray Personnel			
Clinical Support Staff (Medical Assistants, etc)			
Volunteer Clinical Providers (Medical and Dental)		N/A	N/A
DENTAL STAFF			
Dentists			
Dental Hygienists			
Dental Assistants, Aides, Technicians			
MENTAL HEALTH STAFF			
Mental Health Specialists (MH Provider)			
Alcohol and Substance Abuse Specialists			
Psychiatrists			
Psychologists			
ENABLING STAFF			
Patient Education Specialist (Health Educator)			
Case Managers			
Outreach (Outreach Staff)			
Other Enabling			
OTHER PROFESSIONAL STAFF (discuss in narrative as appropriate)			
OTHER STAFF			

DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 3 - INCOME ANALYSIS FORM	FOR HRSA USE ONLY			
	Grantee Name			
	Grant Number		Application Tracking Number	

PART 1: NON FEDERAL SHARE, PROGRAM INCOME								
Payor Category	**Number Of Visits**	**Average Charge Per Visit**	**Gross Charges (a * b)=(c)**	**Average Adjustment Per Visit**	**Net Charges (Amount Billed) [c-(a*d)]**	**Collection Rate (%)**	**Projected Income (e * f)**	**Actual Accrued Income Past 12 Months**
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
PROJECTED FEE FOR SERVICE INCOME								
1a. Medicaid: Medical								
1b. Medicaid: EPSDT (if different from medical rate)								
1c. Medicaid: Dental								
1d. Medicaid: MH/SA								
1e. Medicaid: other fee for Service								
1. Subtotal: Medicaid								
2a. Medicare: all inclusive FQHC rate								
2b. Medicare: other Fee for Service								
2. Subtotal: Medicare								
3a. Private Insurance (Medical)								
3b. Private Insurance (Dental)								
3c. Private Insurance (MH/SA)								
3. Subtotal: Private								
4a. Self-Pay: 100% charge, no discount (Medical)								
4b. Self-Pay: 0% - 99% of charge, Sliding discounts including full discount (Medical)								
4c. Self-Pay: 100% charge, no discount (Dental)								
4d. Self-Pay: 0% - 99% of charge, Sliding discounts including full discount (Dental)								
4e. Self-Pay: 100% charge, no discount (MH/SA)								
4f. Self-Pay: 0% - 99% of charge, sliding discount including full discount, (MH/SA)								
4. Subtotal: Self Pay								
5. Subtotal: Other Public								
6. TOTAL FEE FOR SERVICE								

PROJECTED CAPITATED MANAGED CARE INCOME					
TYPE OF PAYOR	**Number of**	**Rate Per**	**Risk Pool**	**FQHC and**	**Projected Gross**

	Member Months (a)	Member Month (b)	Adjustment (c)	Other Adjustments (d)	Income (e)
7a. Medicaid:					
7b. Medicare					
7c. Commercial					
7d. Other Public					
7. TOTAL CAPITATED MANAGED CARE					
8. Managed Care Charges	**(a) Visits**		**(b) Average Charge Per Visit**		**(c) Total Charges**
TOTAL PROGRAM INCOME [line 6, column g + line 7, column e] Matches line7 "Program Income" of SF 424A					

PART 2: NON-FEDRAL SHARE, OTHER INCOME	
	Total Other Income by Source
9. Applicant	
10. State Funds	
11. Local Funds	
Other Support	
12a. Other Federal Grants	
12b. Contributions and Fundraising	
12c. Foundation Grants	
12d. Other_____(please list)	
12. Subtotal Other Support	
13. TOTAL OTHER INCOME	
TOTAL NON-FEDERAL SHARE [line6, row (g) + line 7, row (e) + line 13] Matches line 5, column f, "Non Federal" Totals of SF 424A	

Comments/Explanatory Notes for Income Analysis Form (if applicable):

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DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 5A: SERVICES PROVIDED	FOR HRSA USE ONLY	
	Application Tracking Number	Grant Number

SERVICE TYPE	MODE OF SERVICE PROVISION		
	APPLICANT	AGREEMENT (Grantee pays for service)	REFERRAL ARRANGEMENTS (Grantee DOES NOT pay)
Required Services			
Clinical Services			
General Primary Medical Care			
Diagnostic Laboratory			
Diagnostic X-Ray			
Screenings			
• Cancer			
• Communicable Diseases			
• Cholesterol			
• Blood lead test for elevated blood lead level			
• Pediatric vision, hearing and dental			
Emergency Medical Services			
Voluntary Family Planning			
Immunizations			
Well Child Services			
Gynecological Care			
Obstetrical Care			
Prenatal and Perinatal Services			
Preventive Dental			
Referral to Mental Health[1]			
Referral to Substance Abuse[1]			
Referral to Specialty Services			
Pharmacy			
Substance Abuse services (required for HCH programs):			
• Detoxification			
• Outpatient Treatment			
• Residential Treatment			
• Rehabilitation (non hospital settings)			
Non - Clinical Services			
Case Management			
• Counseling/Assessment			
• Referral			
• Follow-up/Discharge Planning			
• Eligibility Assistance			
Health Education			
Outreach			
Transportation			

Translation[2]			
Substance abuse services (required for HCH programs):			
• Harm/Risk Reduction (e.g. educational materials, nicotine gum/patches)			
Additional Services (Optional)			
Clinical Services			
Urgent Medical Care			
Dental Services			
• Restorative			
• Emergency			
Mental Health Services			
• Treatment/Counseling			
• Developmental Screening			
• 24-Hour Crisis			
Substance Abuse Services			
Recuperative Care			
Environmental Health Services			
Occupational-Related Health Services[3]			
• Screening for Infectious Diseases			
• Injury Prevention Programs			
Occupational Therapy			
Physical Therapy			
HIV Testing			
TB Therapy			
Hepatitis C			
• Screening			
• Therapy/Treatment			
Podiatry			
Rehabilitation (Non-Hospital Settings)			
Specialty (Please Specify: _____)			
Other (Please Specify: _____)			
Non Clinical Services			
WIC			
Nutrition (not WIC)			
Child Care			
Housing Assistance			
Employment and Education Counseling			
Food Bank/Meals			
Specialty (Please Specify: _____)			
Other (Please Specify: _____)			

1. **Applicants are required to provide mental health and substance abuse services by referral arrangements. However, applicants may provide these services by applicant or formal agreement in addition to by referral arrangements under additional services.**
2. **Required for Health Centers serving a substantial number of patients with limited English-Proficiency.**
3. **Additional Services for Health Centers serving Migrant and seasonal farm workers (MSFWs).**

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DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 5B: SERVICE SITES	FOR HRSA USE ONLY	
	Application Tracking Number	Grant Number

Site Information			
Name of Service Site		Service Site Type	
Location Type		Location Setting	
Number of Contract Service Delivery Locations (Voucher Screening Only)		Number of Intermittent Sites (Intermittent Only)	
Web URL			
Site Operated by	**[_]** Applicant **[_]** Contractor **[_]** Sub-Recipient		

If Site is operated by Sub-recipient or Contractor please provide the organization information below:

Organization	
Organization Name	
Address (Physical)	
Address (mailing)	
EIN	
Comments	

Date Site was Opened		Date Site was Added to Scope	
Site Operational By		Medicare Billing Number	
Medicaid Billing Number		Medicaid Pharmacy Billing Number	
Site Phone Number		Site Fax Number	
Site Physical Address			
Site Mailing Address (Including Mailstop Code, Division/Department Name, and Company)			
Administration Phone Number		Service Area Population	**[_]** Urban **[_]** Rural
Service Area Zip codes			
Service Area Census Tracts			
Operational Schedule	**[_]** Full-Time **[_]** Part-Time	Calendar Schedule	**[_]** Year-Round **[_]** Seasonal
Total Hours of Operation when Patients will be Served per Week (include extended hours)		Months of Operation	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 5C: OTHER ACTIVITIES/LOCATIONS	FOR HRSA USE ONLY	
	Application Tracking Number	Grant Number

ACTIVITY/LOCATION	
Type of Activity	
Description of Activity	
Frequency of Activity	
Type of Location(s) where Activity is Conducted	
ACTIVITY/LOCATION	
Type of Activity	
Description of Activity	
Frequency of Activity	
Type of Location(s) where Activity is Conducted	
ACTIVITY/LOCATION	
Type of Activity	
Description of Activity	
Frequency of Activity	
Type of Location(s) where Activity is Conducted	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 6 - PART A: CURRENT BOARD MEMBER CHARACTERISTICS	FOR HRSA USE ONLY	
	Grantee Name	Application Tracking Number

BOARD MEMBER NAME	BOARD OFFICE HELD	AREA OF EXPERTISE (Place asterisk (*) if member derives more than 10% of income from health industry)	HEALTH CENTER PATIENT	LIVE OR WORK IN SERVICE AREA	YEARS OF CONTINUOUS BOARD SERVICE	SPECIAL POPULATION REPRESENTATIVE (If Yes, specify Special Population)
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						

Gender	Number of Board Members
Male	
Female	
Unreported	
Ethnicity	**Number of Board Members**
Hispanic Origin	
Hispanic or Latino	
Unreported	
Race	**Number of Board Members**
White	
Native Hawaiian or Other Pacific Islander	
Black/African American	
American Indian or Alaska Native	
Asian	
More Than One Race	
Unreported	

Note: (1) Tribal organizations are exempt from completing Form 6A.

(2) MHC, HCH, and/or PHPC applicants requesting a waiver of the governance requirements must complete Form 6 - Part B and describe any alternative arrangement for addressing Board requirements including the mechanism for receiving consumer input.

(3) Add additional pages, if needed.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 8: HEALTH CENTER AFFILIATION CERTIFICATION/CHECKLIST	FOR HRSA USE ONLY	
	Application Tracking Number	Grant Number

Does your organization have, or propose to establish as part of this application, any of the following Affiliation Types:

- Contract for a substantial portion of the approved scope of project
- Memorandum of Understanding (MOU)/Agreement (MOA) for substantial portion of the approved scope
- Contract with another organization or individual contract for core primary care providers
- Contract with another organization for staffing health center
- Contract with another organization for the Chief Medical Officer (CMO) or Chief Financial Officer (CFO)
- Merger with another organization
- Parent Subsidiary Model arrangement
- Acquisition by another organization
- Establishment of a New Entity (e.g. Network corporation)

[_] Yes (Please complete sections **Organization Affiliations** Section)
[_] No
[_] Not Applicable (Choose this option if you are **NOT** a CHC/MHC applicant)

NOTE: You must complete a checklist for each organization with which you have any of the above arrangements. Copies of all applicable documents must be included with the application.

Organization Affiliation Details	
Organization Name	
EIN	
Physical Location Address	

Affiliation Type (Check all that apply)

[_] Contract for a substantial portion of the approved scope of project
[_] Memorandum of Understanding (MOU)/Agreement (MOA) for substantial portion of the approved scope
[_] Contract with another organization or individual contract for core primary care providers
[_] Contract with another organization for staffing health center
[_] Contract with another organization for the Chief Medical Officer (CMO) or Chief Financial Officer (CFO)
[_] Merger with another organization
[_] Parent Subsidiary Model arrangement
[_] Acquisition by another organization
[_] Establishment of a New Entity (e.g. Network corporation)

Description	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **Health Resources and Services Administration** **HEALTH CENTER AFFILIATION CHECKLIST**	**FOR HRSA USE ONLY**			
	Grantee Name			
	Grant Number		Application Tracking Number	

STAFFING:	**YES**	**NO**
1) The center directly employs the CFO, CMO and the core staff of full-time primary care providers.	[_]	[_]
2) The center directly employs all non-provider health center staff.	[_]	[_]
If NO to question 1 or 2, the CEO of the center retains the authority to select and dismiss the CFO and CMO as well as other staff assigned to the center? Please cite reference document and page # (_____)	[_]	[_]
GOVERNANCE:	**YES**	**NO**
3) The arrangements presented in the affiliation agreements, as defined in FORM 8, do not compromise the Board authorities or limit its legislative and regulatory mandated functions and responsibilities as defined below. *(Examples of compromising arrangements are: overriding approval or veto authority by another entity; dual majority requirements; super-majority requirements; or hiring and dismissal of the CEO).*	[_]	[_]
	Reference Document	**Page #**
• board composition		
• executive committee function and composition		
• selection of board chairperson		
• selection of board members		
• strategic planning		
• approval of the annual budget of the center		
• directly employs, selects/dismisses and evaluates the Chief Executive Officer/Executive Director		
• adoption of policies and procedures for personnel and financial management		
• establishes center priorities		
• establishes eligibility requirements for partial payment of services		
• provides for an independent audit		
• evaluation of center activities		

• adoption of center's health care policies including scope and availability of services, location, hours of operation and quality of care audit procedures		
• existence of a conflict of interest policy		
• contains appropriate provisions around the activities to be performed, time, schedules, the policies and procedures to be followed in carrying out the agreement, and the maximum amount of money for which the grantee may become liable to the contractor under the agreement;		
• requires the contractor to maintain appropriate financial, program and property management systems and records in accordance with 45 CFR Part 74 and provides the center, DHHS and the U.S. Comptroller General with access to such records;		
• requires the submission of financial and programmatic reports to the health center;		
• complies with Federal procurement standards or grant requirements including conflict of interest standards;		
• subject to termination (with administrative, contractual and legal remedies) in the event of breach by the contractor.		
CONTRACTING:	**YES**	**NO**
6) The center has justified the performance of the work by a third party. Please cite reference document and page # (_____)	[_]	[_]
7) Written affiliation agreement(s) comply with current Department of Health and Human Services (HHS) policies (PINs 97-27 and 98-24)	[_]	[_]

INCLUDE LIST AND COPIES OF ALL RELEVANT AND CITED DOCUMENTS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES Health Resources and Services Administration FORM 12: ORGANIZATION CONTACTS	FOR HRSA USE ONLY	
	Application Tracking Number	Grant Number

Medical Director	
Name	
Phone	
Email	
Dental Director	
Name	
Phone	
Email	
Chief Executive Officer	
Name	
Phone	
Email	
Contact Person	
Title of Position	
Name	
Phone	
Email	